

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12030

11994

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185

1. PLACE OF DEATH: COUNTRY <u>Harford Maryland</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harford</u> TOWN <u>Harford</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural, give location) <u>170 Deen</u>			
3. NAME OF DECEASED: (Type or Print) <u>Casper</u> (First) <u>Ansolvish</u> (Middle) <u>Ansolvish</u> (Last)				4. DATE OF DEATH <u>December 31</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>8/19/1894</u>	9. AGE, last birthday: <u>61</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Ansolvish</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-14-6693</u>		17. INFORMANT & ADDRESS: <u>John Ansolvish, Harford, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Crushing injury R chest</u> DUE TO							
Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture both lower both legs</u>							
19a. DATE OF OPERATION: _____		19b. MAJOR FINDING OF OPERATION: _____					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/31/55 9P.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident, into auto type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>11/1/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		LOCATION (City, town, or county) <u>Brooklyn, Md.</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>Jan. 3-1956</u>		REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>		24. FUNERAL DIRECTOR <u>Harford</u>		ADDRESS <u>Harford, Md.</u>	

BUREAU V. S.

JAN 4 1954

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12021

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-905

No. 185-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harford</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Harford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS <u>170 E. Deen</u> (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Reba MORRISON Anselvish</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 31 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>3/28/1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Rising Sun</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel M. Morrison</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Holden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Samuel M. White, Rising Sun, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Fracture skull</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>12/31/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>		21c. (City or town) (County) (State): <u>Harford Harford Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12/31/55 9P M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>A rth accident, auto onto type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Donald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/1/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Brookview</u>		LOCATION (City, town, or county) (State): <u>Rising Sun, Md.</u>	
DATE REC'D BY LOCAL REG: <u>Jan 3-1956</u>		REGISTRAR'S SIGNATURE: <u>G. A. Lewis M. d.</u>		24. FUNERAL DIRECTOR: <u>Thurman J. Jones</u>		ADDRESS: <u>Harford Md.</u>	

RECEIVED

JAN 2 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12004

CERTIFICATE OF DEATH

11996

Reg. Dist. No. 151

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>West Virginia</i> COUNTY <i>Monroe</i>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Aberdeen</i>				TOWN <i>Laurel Branch</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>#320 S. Phila Blvd.</i>				STREET ADDRESS (If rural give location) <i>85X-3</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Virginia</i>		(Middle) <i>Patherine</i>		(Last) <i>Arthur</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>Oct 16 - 1861</i>	
				9. AGE last birthday <i>94</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House helper</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>William Arthur</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Helmers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Maggie Campbell Box #289 Aberdeen Md.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Arterio Sclerosis Cardiovascular</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Coronary Thrombosis</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 1, 1955</i> , to <i>Dec 12, 1955</i> , that I last saw the deceased alive on <i>Dec 12 1955</i> , and that death occurred at <i>4:00</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley</i> M.D.				DATE SIGNED <i>Dec 12/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>12/13/55</i>		NAME OF CEMETERY OR CREMATORY <i>Arthur Cemetery</i>		LOCATION (City, town, or county) (State) <i>Laurel Branch West Virginia</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Hellie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarving</i>		ADDRESS <i>Aberdeen Md.</i>	
DATE <i>Dec-13-55</i>							

12005

11997

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 180-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>David de Grace</u>	<u>2.3 mos</u>	TOWN <u>David de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>667 Otsego St</u>		STREET ADDRESS (If rural, give location) <u>667 Otsego St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>JAMES EARNEST BANTON</u>		<u>Dec 19 19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>May 2 1892</u>
9. AGE last birthday: <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Widow Mary Bond</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Raymond L Banton, Balto 25, Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Thrombosis</u> DUE TO		<u>instant</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Carcinoma Stomach with metastases</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Philip W. Durnan</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec 19, 55</u>	
M. D. ASSISTANT MEDICAL EXAM. <u>Dec 19, 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>12/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Frankford</u>		LOCATION (City, town, or county) (State) <u>Frankford W. Va</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Dec 20-1955 G. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>Funeral Home of Grace, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 23 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11998

12022 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hickory</u>		<u>84415</u>		TOWN <u>Hickory</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Forest Hill RD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>PRESTON THE COMAS BARROW</u>				<u>DEC 27 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>JULY 24 1871</u>	<u>54</u> yrs.	Months <u>5</u>	Days <u>3</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Retired</u>		<u>Chestnut Hill MD</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN H. BARROW</u>				<u>Margaret Stump Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Edwin S. Barrow Forest Hill MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic CV Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Lerald C Palmer</u>		<u>M.D. Deputy Medical Examiner</u>		<u>12/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>DEC 30 55</u>		<u>Deer Creek</u>		<u>Chestnut Hill MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>12-30-55</u>		<u>Priscilla Townsend</u>		<u>Wm. H. Keith Jr. Chestnut Hill MD</u>			

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RECEIVED
JAN 2 1956
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Name of Deceased John H. Blair		Sex Male		Race White	
Date of Birth July 24 1871		Age 84		Marital Status Married	
Place of Birth Chestnut Hill Md		Occupation Farmer		Cause of Death Heart Failure	
Date of Death Dec 27 1955		Place of Death Chestnut Hill Md		Physician's Signature Dr. J. H. Blair	
Signature of Informant John H. Blair		Signature of Physician Dr. J. H. Blair		Signature of Registrar Dr. J. H. Blair	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12000

12023 **CERTIFICATE OF DEATH**

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		LENGTH OF STAY (in this place) <u>9 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>Stepney</u>		(If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Isaac David Booth</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 29, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 16, 1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home construction</u>		11. BIRTHPLACE (State or foreign country) <u>Roanoke Va.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Booth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sigmon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes WW I 1 day</u>		16. SOCIAL SECURITY NO. <u>218-12-4251</u>		17. INFORMANT & ADDRESS <u>William L. Quinn, Aberdeen R.D. 2 Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>420.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 1 1/2 yrs.</u>	
2. ANTECEDENT CAUSE(S) DUE TO <u>Coronary Occlusion</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO <u>Arteriosclerosis</u>							
4. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Congenitive C-V. Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1, 1955, to Dec 29, 1955, that I last saw the deceased alive on Dec 1, 1955, and that death occurred at 1 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Alex. Sandecki M.D.</u>				ADDRESS (Street, city, town, state) <u>BEL AIR, Md</u>		DATE SIGNED <u>12.29.1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Quinn & Booth</u>		LOCATION (City, town, or county) (State) <u>Ferrum, Franklin Co., Va.</u>	
24. REC'D BY REGISTRAR <u>Jan. 2-56</u>		REGISTRAR'S SIGNATURE <u>Nellie P Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas & Son Abingdon, Md.</u>			

CERTIFICATE OF DEATH

For District

A. MAJOR SECTION FOR FINGER OR ORGANOID

1. PLACE OF DEATH

NAME	DATE	TIME	PLACE
JOHN CARROLL HARRIS	1956	10:00 AM	HOME

SEX	AGE	EDUCATION	RELIGION
MALE	67	8 YEARS	ROMAN CATHOLIC

CAUSE OF DEATH	DATE OF DEATH
HEART DISEASE	1956

DATE OF DEATH	PLACE OF DEATH
1956	HOME

DATE OF DEATH	PLACE OF DEATH
1956	HOME

BUREAU V. S.

JAN 4 1956

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12024 CERTIFICATE OF DEATH

12001

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		LENGTH OF STAY (in this place) <u>R. 5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill (Rural)</u>		X	
OR TOWN <u>Forest Hill MD</u>				OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location)		/	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LOUISE C. CARCAUD</u>				<u>Dec 8 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 19-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Earingberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Mr. H. M. Boyce 4761 Eastern Ave Baltimore MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442x IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				<u>32 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypercholesterolemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>				<u>10 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 1953, to <u>Dec 8</u> , 1955, that I last saw the deceased alive on <u>Dec 7</u> , 1955, and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson M.D. Forest Hill</u>				DATE SIGNED <u>MD 12/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec 12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) <u>Forest Hill (Rural) MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Purilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster Belau</u>		ADDRESS	
DATE <u>12-8-55</u>							

BUREAU V. S.

DEC 12 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film G191 1-16-56 am

12002

CERTIFICATE OF DEATH

Reg. Dist. No. 184

12006

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Md.</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace</u>		<u>20 days</u>		TOWN <u>Port Deposit</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS <u>R. D #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Hester</u> (First) <u>Clark</u> (Last)				<u>12</u> <u>30</u> <u>1953</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>unknown</u>	<u>about 87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House-Wife</u>				<u>Maryland</u>			
13. FATHER'S NAME <u>Samuel Chambers</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>George Clark</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
916.0 IMMEDIATE CAUSE (A) <u>Burns 2+3° 50% Surface</u>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterio-sclerotic Cardio-Vascular Disease</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Port Deposit Maryland</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/11/55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Sleeping gown caught fire from stove</u>			
22. I hereby certify that I attended the deceased from <u>12-11</u> , 19 <u>53</u> , to <u>12-30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>53</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Brundage</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>12-30-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cokeburg</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Debra Patterson</u>		ADDRESS <u>4 Son, Berryville Md</u>	
DATE <u>Dec. 31-55</u>							

15008

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 22

CERTIFICATE OF DEATH

15008

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		CITY	
ST. LOUIS, MISSOURI		MISSOURI	
OCCUPATION		PROFESSOR	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	

undetermined
undetermined

me

BUREAU V. S.

13-30 22 13-11 02 15-30 22
 1968 JAN 2

Received
1-3-1968
James Earl Ray
St. Louis, Missouri

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12007

CERTIFICATE OF DEATH

12003

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>MD</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Harford</u>		<u>11 days</u>		OR TOWN <u>Harford</u>			
HOSPITAL OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>568 Congress Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Myrtle Coakley</u>				<u>Dec. 1 19 55</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>AUG 25, 1968</u>	
						9. AGE last birthday <u>87</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Barnaby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>PERCY COAKLEY HARFORD DE GRACE MD</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Arterio Sclerosis Cardio</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Coronary Thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Symptoms</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 20, 19 55</u> , to <u>Dec. 1, 19 55</u> , that I last saw the deceased alive on <u>Dec. 1, 19 55</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford De Grace Md</u> DATE SIGNED <u>12/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL CEM.</u>		LOCATION (City, town, or county) (State) <u>HARFORD DE GRACE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. Madison Mitchell</u>		ADDRESS <u>HARFORD DE GRACE, MD</u>	
DATE <u>Dec. 3-55</u>							

CERTIFICATE OF DEATH

2007

High Court No.

IN WITNESS WHEREOF I HAVE HEREON SIGNED

DATE OF DEATH

STATE OF MARYLAND

COUNTY OF BALTIMORE

DATE

TIME

Age 22 1/2 27

Home

Home

DEATH CERTIFICATE HAS BEEN DELETED

BUREAU V. S.

DEC 5 1955

RECEIVED

MD HANDED OFF

DEC 3 1955

BUREAU

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, but not later than 72 hours after death. It should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. It should be kept for a period of 10 years.

12008

12004

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 185

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Harford	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Harve de Grace	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Belcamp	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) David	(Middle) Allen	(Last) Crouse	(Month) 12 (Day) 27 (Year) 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Sept. 20, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none		10b. KIND OF BUSINESS OR INDUSTRY: none	9. AGE last birthday: 3 yrs. 3 Months 3 Days 3 Hours 3 Min.
11. BIRTHPLACE (State or foreign country): Harford Co., Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Virgil Crouse		14. MOTHER'S MAIDEN NAME: Irene Curley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: none	
17. INFORMANT & ADDRESS: Virgil Crouse, Belcamp, Maryland.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Laryngo-tracheo-bronchitis		
Immediate cause DUE TO		
(b) Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Paul H. Merri</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/27/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Dec. 28, 1955	NAME OF CEMETERY OR CREMATORY Cokesbury
LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	24. FUNERAL DIRECTOR Howard K. Mc Comas & Son, Abingdon, Md.,	
DATE REC'D BY LOCAL REG. Dec. 27-55	REGISTRAR'S SIGNATURE <i>L. Lewis</i>	

2095294386

Howard K. Mc Comas & Son

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED

DEC 30 1955

RECEIVED

12009

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12005
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 133

1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN

Laurel & Grace

LENGTH OF STAY
(In this place)
T.O.A.HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Harford Memorial Hopt.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Harford

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN

Perryman

STREET

ADDRESS

(If rural, give location)

Rural #1 Aberdeen

3. NAME OF
DECEASED:
(Type or Print)

(First)

Jacob

(Middle)

(Last)

Decker

4. DATE

(Month)

(Day)

(Year)

OF
DEATH

December 28 1955

5. SEX:

Male

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Single

8. DATE OF BIRTH:

Mar 8th 1888

9. AGE last birthday:

67

yrs.

IF UNDER 1 YEAR | IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Watchman

10b. KIND OF BUSINESS OR
INDUSTRY:

Railroad

11. BIRTHPLACE (State or foreign country):

Pennsylvania

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME:

Wm H Yeckman

14. MOTHER'S MAIDEN NAME:

Margaret H. Hoopes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

Yes

War I.

16. SOCIAL SECURITY No.:

717-07-5671

17. INFORMANT & ADDRESS:

Wm H Yeckman & Margaret H. Hoopes Aberdeen R.I.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

(a) Hypertensive Cardiovascular disease

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Renal calculus

INTERVAL BETWEEN
ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF
street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF
INJURY

M.

21e. INJURY OCCURRED
While at
work ☐ Not while
at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Lerald C Palmer

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

12/28/55

23. BURIAL, CREMATION,
REMOVAL (Specify):

Burial

DATE THEREOF

12/31/55

NAME OF CEMETERY OR CREMATORY

Cranberry Methodist

LOCATION (City, town, or county)

Perryman Maryland

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

J. L. F. Fawcett

24. FUNERAL DIRECTOR

John G. Fawcett Aberdeen Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12006

12025 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Street Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Street, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Martha Jane Gray</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 10, 1897</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Presbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT & ADDRESS <u>Estella Presbury</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Burlington, Md</u>	
443X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hyper tensive Cardiovascular disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6</u> , 19 <u>53</u> , to <u>12/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>55</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city, town, state) <u>Revolution St. Havre de Grace, Md.</u>	
DATE <u>Dec. 24, 1955</u>		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Haranna Cem</u>	
DATE THEREOF <u>Dec. 24, 1955</u>		LOCATION (City, town, or county) <u>Harford Co, Md</u>	
24. REC'D BY REGISTRAR <u>C. H. Kirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>	
REGISTRAR'S SIGNATURE		ADDRESS <u>Burlington Md</u>	

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased.
2. It should be filled out as soon as possible after death.
3. It should be filled out in ink.
4. It should be filled out in the presence of the deceased's family or friends.
5. It should be filled out in the presence of the deceased's physician or other person who has attended the deceased.
6. It should be filled out in the presence of the deceased's family or friends.
7. It should be filled out in the presence of the deceased's physician or other person who has attended the deceased.
8. It should be filled out in the presence of the deceased's family or friends.
9. It should be filled out in the presence of the deceased's physician or other person who has attended the deceased.
10. It should be filled out in the presence of the deceased's family or friends.

1908 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. No. 100

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Nature of disease

9. Duration of disease

10. Name of physician

11. Name of hospital

12. Name of funeral home

13. Name of undertaker

14. Name of cemetery

15. Name of burial place

16. Name of interment

17. Name of cremation

18. Name of other disposition

BUREAU V. S.

DEC 30 1905

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12010

CERTIFICATE OF DEATH

12007

Reg. Dist. No. 180-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u> MARYLAND		STATE <u>Md</u> COUNTY <u>Hartford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		TOWN <u>Bel Air</u>	
CITY OR TOWN <u>Hartford</u>		LENGTH OF STAY (In this place) <u>4 hrs</u>		STREET ADDRESS (If rural give location) <u>RT #3 Box 200</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>	
3. NAME OF DECEASED (Type or Print) <u>Evelyn Virginia Hendrickson</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>11-5-14</u>	9. AGE last birthday <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Hendrickson</u>				14. MOTHER'S MAIDEN NAME <u>Francis C. Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
592X IMMEDIATE CAUSE (A) <u>Nremia and acidosis</u>				<u>1 wk.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Glomerulonephritis</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 13/55, 1955, to Dec 13/55, 1955, that I last saw the deceased alive on Dec 13/55, 1955, and that death occurred at 4:35 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Howard K. McGonagles</u>				ADDRESS (Street, city, town, state) <u>430 N. Union Ave. Havre de Grace, Md.</u> DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McGonagles & Son, Abingdon, Md.</u>			
DATE <u>Dec. 16-1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12011

CERTIFICATE OF DEATH

12008

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 Essex Place</u>				STREET ADDRESS (If rural give location) <u>21 Essex Place</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mabel</u> <u>Vaughn</u> <u>Hillman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec</u> <u>24</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 29, 1879</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Bitler</u>				14. MOTHER'S MAIDEN NAME <u>Francine Dutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Earl Stanley Hillman, 21 Essex Place, Aberdeen, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Myocardial failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 Dec</u> , 19 <u>55</u> , to <u>19 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>19 Dec</u> , 19 <u>55</u> , and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Earl Stanley Hillman</u>		M. D. <u>USA Hospital, Aberdeen Pr Gr, Md</u>		DATE SIGNED <u>27 Dec 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Unity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Unity, Waldo Co. Maine</u>	
24. REC'D BY REGISTRAR <u>12/29/55</u>		REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Fanning</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12009

12012

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Harre de Grace</i>		<i>12 yrs.</i>		TOWN <i>Harre de Grace, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elizabeth Street</i>				STREET ADDRESS (If rural give location) <i>Elizabeth Street</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Carrie M. James</i>				<i>12 - 12 - 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDEF. 24 HRS.
<i>Female</i>	<i>Negro</i>	<i>Widowed</i>	<i>Feb. 15, 1898</i>	<i>57</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>				<i>Rosehill, N. C.</i>		<i>U. S. A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Unknown</i>				<i>Senny Powers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
				<i>Elizabeth Street</i> <i>Mr. Jet James - Harre de Grace, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>420.0</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
<i>Coronary Thrombosis</i>							
<i>Hypertensive - Arteriosclerotic Heart Disease</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not white <input type="checkbox"/>					
		M. <input type="checkbox"/> el work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>2/31</i>, 19 <i>51</i>, to <i>12/11</i>, 19 <i>55</i>, that I last saw the deceased alive on <i>12/11</i>, 19 <i>55</i>, and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>George T. Stansbury</i>				<i>M. D. 569 Revolution St. Harre de Grace, Md.</i>		<i>12/12/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Removal</i>		<i>12-14-55</i>		<i>Halls Cemetery</i>		<i>Rosehill, N. C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>12-14-55</i>		<i>A. L. Lewis M. D.</i>		<i>Atelis J. Bullock - Harre de Grace, Md.</i>			

RECEIVED

DEC 16 1935

BUREAU V. S.

X

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. DATE OF BIRTH		4. SEX	
5. DATE OF DEATH		6. CAUSE OF DEATH	
7. PLACE OF DEATH		8. MANNER OF DEATH	
9. OCCUPATION		10. EDUCATION	
11. MARITAL STATUS		12. RELIGION	
13. SOCIAL STATUS		14. RACE	
15. COLOR		16. HEIGHT	
17. WEIGHT		18. BUILD	
19. COMPLEXION		20. HAIR	
21. EYES		22. TEETH	
23. SKIN		24. FINGERPRINTS	
25. SIGNATURE		26. DATE	
27. ADDRESS		28. CITY	
29. STATE		30. COUNTY	
31. ZIP CODE		32. PHONE	
33. MAILING ADDRESS		34. TELEPHONE	
35. TELETYPE		36. RADIO	
37. TELEVISION		38. OTHER	
39. COMMENTS		40. SIGNATURE	
41. DATE		42. CITY	
43. STATE		44. COUNTY	
45. ZIP CODE		46. PHONE	
47. MAILING ADDRESS		48. TELEPHONE	
49. TELETYPE		50. RADIO	
51. TELEVISION		52. OTHER	
53. COMMENTS		54. SIGNATURE	
55. DATE		56. CITY	
57. STATE		58. COUNTY	
59. ZIP CODE		60. PHONE	
61. MAILING ADDRESS		62. TELEPHONE	
63. TELETYPE		64. RADIO	
65. TELEVISION		66. OTHER	
67. COMMENTS		68. SIGNATURE	
69. DATE		70. CITY	
71. STATE		72. COUNTY	
73. ZIP CODE		74. PHONE	
75. MAILING ADDRESS		76. TELEPHONE	
77. TELETYPE		78. RADIO	
79. TELEVISION		80. OTHER	
81. COMMENTS		82. SIGNATURE	
83. DATE		84. CITY	
85. STATE		86. COUNTY	
87. ZIP CODE		88. PHONE	
89. MAILING ADDRESS		90. TELEPHONE	
91. TELETYPE		92. RADIO	
93. TELEVISION		94. OTHER	
95. COMMENTS		96. SIGNATURE	
97. DATE		98. CITY	
99. STATE		100. COUNTY	
101. ZIP CODE		102. PHONE	
103. MAILING ADDRESS		104. TELEPHONE	
105. TELETYPE		106. RADIO	
107. TELEVISION		108. OTHER	
109. COMMENTS		110. SIGNATURE	
111. DATE		112. CITY	
113. STATE		114. COUNTY	
115. ZIP CODE		116. PHONE	
117. MAILING ADDRESS		118. TELEPHONE	
119. TELETYPE		120. RADIO	
121. TELEVISION		122. OTHER	
123. COMMENTS		124. SIGNATURE	
125. DATE		126. CITY	
127. STATE		128. COUNTY	
129. ZIP CODE		130. PHONE	
131. MAILING ADDRESS		132. TELEPHONE	
133. TELETYPE		134. RADIO	
135. TELEVISION		136. OTHER	
137. COMMENTS		138. SIGNATURE	
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141. STATE		142. COUNTY	
143. ZIP CODE		144. PHONE	
145. MAILING ADDRESS		146. TELEPHONE	
147. TELETYPE		148. RADIO	
149. TELEVISION		150. OTHER	
151. COMMENTS		152. SIGNATURE	
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155. STATE		156. COUNTY	
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159. MAILING ADDRESS		160. TELEPHONE	
161. TELETYPE		162. RADIO	
163. TELEVISION		164. OTHER	
165. COMMENTS		166. SIGNATURE	
167. DATE		168. CITY	
169. STATE		170. COUNTY	
171. ZIP CODE		172. PHONE	
173. MAILING ADDRESS		174. TELEPHONE	
175. TELETYPE		176. RADIO	
177. TELEVISION		178. OTHER	
179. COMMENTS		180. SIGNATURE	
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185. ZIP CODE		186. PHONE	
187. MAILING ADDRESS		188. TELEPHONE	
189. TELETYPE		190. RADIO	
191. TELEVISION		192. OTHER	
193. COMMENTS		194. SIGNATURE	
195. DATE		196. CITY	
197. STATE		198. COUNTY	
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203. TELETYPE		204. RADIO	
205. TELEVISION		206. OTHER	
207. COMMENTS		208. SIGNATURE	
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211. STATE		212. COUNTY	
213. ZIP CODE		214. PHONE	
215. MAILING ADDRESS		216. TELEPHONE	
217. TELETYPE		218. RADIO	
219. TELEVISION		220. OTHER	
221. COMMENTS		222. SIGNATURE	
223. DATE		224. CITY	
225. STATE		226. COUNTY	
227. ZIP CODE		228. PHONE	
229. MAILING ADDRESS		230. TELEPHONE	
231. TELETYPE		232. RADIO	
233. TELEVISION		234. OTHER	
235. COMMENTS		236. SIGNATURE	
237. DATE		238. CITY	
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241. ZIP CODE		242. PHONE	
243. MAILING ADDRESS		244. TELEPHONE	
245. TELETYPE		246. RADIO	
247. TELEVISION		248. OTHER	
249. COMMENTS		250. SIGNATURE	
251. DATE		252. CITY	
253. STATE		254. COUNTY	
255. ZIP CODE		256. PHONE	
257. MAILING ADDRESS		258. TELEPHONE	
259. TELETYPE		260. RADIO	
261. TELEVISION		262. OTHER	
263. COMMENTS		264. SIGNATURE	
265. DATE		266. CITY	
267. STATE		268. COUNTY	
269. ZIP CODE		270. PHONE	
271. MAILING ADDRESS		272. TELEPHONE	
273. TELETYPE		274. RADIO	
275. TELEVISION		276. OTHER	
277. COMMENTS		278. SIGNATURE	
279. DATE		280. CITY	
281. STATE		282. COUNTY	
283. ZIP CODE		284. PHONE	
285. MAILING ADDRESS		286. TELEPHONE	
287. TELETYPE		288. RADIO	
289. TELEVISION		290. OTHER	
291. COMMENTS		292. SIGNATURE	
293. DATE		294. CITY	
295. STATE		296. COUNTY	
297. ZIP CODE		298. PHONE	
299. MAILING ADDRESS		300. TELEPHONE	
301. TELETYPE		302. RADIO	
303. TELEVISION		304. OTHER	
305. COMMENTS		306. SIGNATURE	
307. DATE		308. CITY	
309. STATE		310. COUNTY	
311. ZIP CODE		312. PHONE	
313. MAILING ADDRESS		314. TELEPHONE	
315. TELETYPE		316. RADIO	
317. TELEVISION		318. OTHER	
319. COMMENTS		320. SIGNATURE	
321. DATE		322. CITY	
323. STATE		324. COUNTY	
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327. MAILING ADDRESS		328. TELEPHONE	
329. TELETYPE		330. RADIO	
331. TELEVISION		332. OTHER	
333. COMMENTS		334. SIGNATURE	
335. DATE		336. CITY	
337. STATE		338. COUNTY	
339. ZIP CODE		340. PHONE	
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343. TELETYPE		344. RADIO	
345. TELEVISION		346. OTHER	
347. COMMENTS		348. SIGNATURE	
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357. TELETYPE		358. RADIO	
359. TELEVISION		360. OTHER	
361. COMMENTS		362. SIGNATURE	
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371. TELETYPE		372. RADIO	
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379. STATE		380. COUNTY	
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387. TELEVISION		388. OTHER	
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399. TELETYPE		400. RADIO	
401. TELEVISION		402. OTHER	
403. COMMENTS		404. SIGNATURE	
405. DATE		406. CITY	
407. STATE		408. COUNTY	
409. ZIP CODE		410. PHONE	
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413. TELETYPE		414. RADIO	
415. TELEVISION		416. OTHER	
417. COMMENTS		418. SIGNATURE	
419. DATE		420. CITY	
421. STATE		422. COUNTY	
423. ZIP CODE		424. PHONE	
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427. TELETYPE		428. RADIO	
429. TELEVISION		430. OTHER	
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433. DATE		434. CITY	
435. STATE		436. COUNTY	
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439. MAILING ADDRESS		440. TELEPHONE	
441. TELETYPE		442. RADIO	
443. TELEVISION		444. OTHER	
445. COMMENTS		446. SIGNATURE	
447. DATE		448. CITY	
449. STATE		450. COUNTY	
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453. MAILING ADDRESS		454. TELEPHONE	
455. TELETYPE		456. RADIO	
457. TELEVISION		458. OTHER	
459. COMMENTS		460. SIGNATURE	
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463. STATE		464. COUNTY	
465. ZIP CODE		466. PHONE	
467. MAILING ADDRESS		468. TELEPHONE	
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471. TELEVISION		472. OTHER	
473. COMMENTS		474. SIGNATURE	
475. DATE		476. CITY	
477. STATE		478. COUNTY	
479. ZIP CODE		480. PHONE	
481. MAILING ADDRESS		482. TELEPHONE	
483. TELETYPE		484. RADIO	
485. TELEVISION		486. OTHER	
487. COMMENTS		488. SIGNATURE	
489. DATE		490. CITY	
491. STATE		492. COUNTY	
493. ZIP CODE		494. PHONE	
495. MAILING ADDRESS		496. TELEPHONE	
497. TELETYPE		498. RADIO	
499. TELEVISION		500. OTHER	
501. COMMENTS		502. SIGNATURE	
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505. STATE		506. COUNTY	
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509. MAILING ADDRESS		510. TELEPHONE	
511. TELETYPE		512. RADIO	
513. TELEVISION		514. OTHER	
515. COMMENTS		516. SIGNATURE	
517. DATE		518. CITY	
519. STATE		520. COUNTY	
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527. TELEVISION		528. OTHER	
529. COMMENTS		530. SIGNATURE	
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533. STATE		534. COUNTY	
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537. MAILING ADDRESS		538. TELEPHONE	
539. TELETYPE		540. RADIO	
541. TELEVISION		542. OTHER	
543. COMMENTS		544. SIGNATURE	
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547. STATE		548. COUNTY	
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557. COMMENTS		558. SIGNATURE	
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567. TELETYPE		568. RADIO	
569. TELEVISION		570. OTHER	
571. COMMENTS		572. SIGNATURE	
573. DATE		574. CITY	
575. STATE		576. COUNTY	
577. ZIP CODE		578. PHONE	
579. MAILING ADDRESS		580. TELEPHONE	
581. TELETYPE		582. RADIO	
583. TELEVISION		584. OTHER	
585. COMMENTS		586. SIGNATURE	
587. DATE		588. CITY	
589. STATE		590. COUNTY	
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593. MAILING ADDRESS		594. TELEPHONE	
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599. COMMENTS		600. SIGNATURE	
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603. STATE		604. COUNTY	
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609. TELETYPE		610. RADIO	
611. TELEVISION		612. OTHER	
613. COMMENTS		614. SIGNATURE	
615. DATE		616. CITY	
617. STATE		618. COUNTY	
619. ZIP CODE		620. PHONE	
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623. TELETYPE		624. RADIO	
625. TELEVISION		626. OTHER	
627. COMMENTS		628. SIGNATURE	
629. DATE		630. CITY	
631. STATE		632. COUNTY	
633. ZIP CODE		634. PHONE	
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665. TELETYPE		666. RADIO	
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669. COMMENTS		670. SIGNATURE	
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673. STATE		674. COUNTY	
675. ZIP CODE		676. PHONE	
677. MAILING ADDRESS		678. TELEPHONE	
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681. TELEVISION		682. OTHER	
683. COMMENTS		684. SIGNATURE	
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687. STATE		688. COUNTY	
689. ZIP CODE		690. PHONE	
691. MAILING ADDRESS		692. TELEPHONE	
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713. DATE		714. CITY	
715. STATE		716. COUNTY	
717. ZIP CODE		718. PHONE	
719. MAILING ADDRESS		720. TELEPHONE	
721. TELETYPE		722. RADIO	
723. TELEVISION		724. OTHER	
725. COMMENTS		726. SIGNATURE	
727. DATE		728. CITY	
729. STATE		730. COUNTY	
731. ZIP CODE		732. PHONE	
733. MAILING ADDRESS		734. TELEPHONE	
735. TELETYPE		736. RADIO	
737. TELEVISION		738. OTHER	
739. COMMENTS		740. SIGNATURE	
741. DATE		742. CITY	
743. STATE		744. COUNTY	
745. ZIP CODE		746. PHONE	
747. MAILING ADDRESS		748. TELEPHONE	
749. TELETYPE		750. RADIO	
751. TELEVISION		752. OTHER	
753. COMMENTS		754. SIGNATURE	
755. DATE		756. CITY	
757. STATE		758. COUNTY	
759. ZIP CODE		760. PHONE	
761. MAILING ADDRESS		762. TELEPHONE	
763. TELETYPE		764. RADIO	
765. TELEVISION		766. OTHER	
767. COMMENTS		768. SIGNATURE	
769. DATE		770. CITY	
771. STATE		772. COUNTY	
773. ZIP CODE		774. PHONE	
775. MAILING ADDRESS		776. TELEPHONE	
777. TELETYPE		778. RADIO	
779. TELEVISION		780. OTHER	
781. COMMENTS		782. SIGNATURE	
783. DATE		784. CITY	
785. STATE		786. COUNTY	
787. ZIP CODE		788. PHONE	
789. MAILING ADDRESS		790. TELEPHONE	
791. TELETYPE		792. RADIO	
793. TELEVISION</			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12010
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bel Air</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 No. Bond St.</u>		STREET ADDRESS (If rural, give location) <u>111 No Bond St</u>	
3. NAME OF DECEASED: (Type or Print) <u>GEORGE ROBERT JONES</u>		4. DATE OF DEATH <u>DEC 11 19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married Nov. 23 1888</u>	8. DATE OF BIRTH: <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Handy man</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>67</u> yrs.
13. FATHER'S NAME: <u>JOHN JONES</u>		14. MOTHER'S MAIDEN NAME: <u>SALLY JAMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>214-34-4030</u>	17. INFORMANT & ADDRESS: <u>Wife - Mary Jones, Bel Air, Md.</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Suffocation of Pulmonary Edema</u>			<u>2 days</u>
Antecedent cause(s) (b) <u>Coronary Heart Disease</u>			<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Philip W. Neuman</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>Dec 12, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Dec 14/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist</u>	LOCATION (City, town, or county) <u>Joppa, Harford Md</u>
DATE REC'D BY LOCAL REG. <u>12-13-55</u>	REGISTRAR'S SIGNATURE <u>Priscilla Lowmeyer</u>	FUNERAL DIRECTOR <u>Joe J. Latta Bel Air Md</u>	

RECEIVED

DEC 15 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12014 CERTIFICATE OF DEATH

12011

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford Grace</u>		<u>3 hrs. 5 Min</u>		TOWN <u>Bel Air</u> (<u>Belcamp</u>)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Harford Memorial</u>				<u>Box 137A Route - 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby John Bay Samuel Kludy</u>				<u>Dec. 23</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>Dec. 23, 1955</u>	<u>2</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Kludy</u>				<u>Cecelia Rochester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>John Kludy, Bel Air R.D.#2 Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
759.2 IMMEDIATE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
(A) <u>Congenital absence left diaphragm with</u>				<u>2 hrs 5 min</u>			
ANTECEDENT CAUSE(S) DUE TO <u>rudimentary lung formation.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Frederick J. Stetson</u> M.D. <u>177 N. White Blvd. Bel Air, Md.</u>				<u>12/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 24, 1955</u>		<u>St. Francis</u>		<u>Abingdon, Harford Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>Dec. 27-1955</u>		<u>G. L. Lewis M.D.</u>		<u>Howard K. McComas & Son, Abingdon, Md.</u>			

20V5365395

Howard K. McComas Jr

ST. LOUIS, MO. (AP) — The St. Louis Police Department is looking for a man who was seen running from police officers in the city's central business district.

DEC 28 1955

RECEIVED

1

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12013

12026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>7. Ampton Co.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hazarath</u>		75X3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>APT 3A. Harford Manor</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sabina</u> (Middle) <u>Patherine</u> (Last) <u>Metz</u>				(Month) <u>Dec</u> (Day) <u>1st</u> (Year) <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 20th 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Young</u>				14. MOTHER'S MAIDEN NAME <u>Patherine Bauer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Victor Albrecht Edgewood Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332x IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Nov 23 55</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>myocarditis with auricular fibrillation</u>						<u>some years</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 10, 1955</u> , to <u>Dec 1, 1955</u> , that I last saw the deceased alive on <u>Nov 30, 1955</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John O Hodous</u>		M.D.		ADDRESS (Street, city, town, state) <u>Edgewood Md</u>		DATE SIGNED <u>12-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		LOCATION (City, town, of county) (State) <u>Hazarath, Penna.</u>	
24. REC'D BY REGISTRAR <u>Norma G. Moon</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sabring Aberdeen Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

State of Maryland

1. Usual Residence (House or Apartment)

MARYLAND

2. Place of Death

3. Name of Decedent

4. Date of Death

5. Sex of Decedent

6. Age of Decedent

7. Race of Decedent

8. Cause of Death

9. Manner of Death

10. Name of Physician

11. Name of Coroner

12. Name of Medical Examiner

13. Medical Certification

14. Signature of Medical Examiner

15. Signature of Coroner

16. Signature of Physician

17. Signature of Family

18. Signature of Burial Society

19. Signature of Registrar

20. Signature of Health Officer

21. Signature of County Clerk

22. Signature of State Registrar

23. Signature of State Health Officer

24. Signature of State Coroner

25. Signature of State Physician

26. Signature of State Burial Society

27. Signature of State Registrar

28. Signature of State Health Officer

29. Signature of State Coroner

30. Signature of State Physician

31. Signature of State Burial Society

32. Signature of State Registrar

33. Signature of State Health Officer

34. Signature of State Coroner

35. Signature of State Physician

36. Signature of State Burial Society

37. Signature of State Registrar

BUREAU V. S.

DEC 7 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12014

12027 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Park Rural</u>		<u>36 yrs.</u>		TOWN <u>Joppa Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>C</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Smith</u> (Middle) <u>Levering</u> (Last) <u>Moore</u>				Dec. 7 1955			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 10, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>C</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elina L. B. Moore</u>				14. MOTHER'S MAIDEN NAME <u>C</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hebert M Moore Joppa Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Prostate</u>				<u>2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>55</u> , to <u>Dec.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 6</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city, town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>Dec. 7 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>13 final</u>		DATE THEREOF <u>Dec. 10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		LOCATION (City, town, or county) (State) <u>Wilma Harford Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Arthur</u>		ADDRESS <u>Joppa Md</u>	
DATE <u>12-9-55</u>							

1955 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

REG. NO. 100

DEPARTMENT OF HEALTH - BALTIMORE

DEPARTMENT OF HEALTH - BALTIMORE

NAME

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

DEC 13 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185-

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Georgia</u> COUNTY <u>Jeff Davis</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hazlehurst</u> 49X-3 STREET ADDRESS (If rural, give location) ADDRESS <u>—</u>	
3. NAME OF DECEASED: (Type or Print) <u>Nathan L Murray Jr</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>December 26</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>4/6/1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	9. AGE last birthday: <u>24</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nathan L. Murray Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Temple Dickins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Nancy W. Murray, Harde Road, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Lunchbox Wound Cerebrum</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause stating underlying cause last</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>12/26/55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>	21c. (City or town) <u>Harde Road Harford</u> (County) <u>not</u> (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/26/55 7:32</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Shot self</u>		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>Dorold C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/26/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>12/30/55</u>	NAME OF CEMETERY OR CREMATORY <u>Hazlehurst</u>	LOCATION (City, town, or county) <u>Hazlehurst, Ga.</u> (State)
DATE REC'D BY LOCAL REG. <u>Dec. 27-1955</u>	REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	24. FUNERAL DIRECTOR <u>William J. Lewis, Harde Road, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 30 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12016

12016 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVER DE GRACE</u>		<u>19 hrs</u>		TOWN <u>ABERDEEN</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Mem. Hospital</u>				STREET ADDRESS (If rural give location) <u>41 Liberty ST</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lucy Pearl Norman</u>				<u>Feb 6 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5 March 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXXXXXXX</u>		11. BIRTHPLACE (State or foreign country) <u>Framstown W Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(deceased) Andrew Jackson</u>				14. MOTHER'S MAIDEN NAME <u>(deceased) Mary James</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>41 Liberty St. Letcher Norman. Aberdeen, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio-Sclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>December 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>55</u> , and that death occurred at <u>10</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Hater</u>				ADDRESS (Street, city, town, state) <u>M.D. 1774 Phila. Bld. Parkersburg, Md.</u>		DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>James Cemetery</u>		LOCATION (City, town, or county) <u>Braxton Co. W. Va.</u>	
24. REC'D BY REGISTRAR <u>Dec. 8-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF BIRTH

3. SEX

4. AGE (at death)

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CORoner

20. SIGNATURE OF JURY

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF PROSECUTOR

23. SIGNATURE OF DEFENSE ATTORNEY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF CLERK

26. SIGNATURE OF RECORDER

27. SIGNATURE OF ARCHIVIST

28. SIGNATURE OF LIBRARIAN

29. SIGNATURE OF CURATOR

30. SIGNATURE OF ASSISTANT

31. SIGNATURE OF ATTORNEY AT LAW

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF DEPUTY SHERIFF

34. SIGNATURE OF CONSTABLE

35. SIGNATURE OF JAILER

36. SIGNATURE OF WARDEN

37. SIGNATURE OF CHIEF OF POLICE

38. SIGNATURE OF DETECTIVE

39. SIGNATURE OF INSPECTOR

40. SIGNATURE OF SUPERVISOR

41. SIGNATURE OF CLERK

42. SIGNATURE OF RECORDER

43. SIGNATURE OF ARCHIVIST

44. SIGNATURE OF LIBRARIAN

BUREAU V. 8

DEC 12 1955

RECEIVED

RECEIVED

1. DECEASED'S NAME (Last, first, middle)
2. PLACE OF BIRTH
3. SEX
4. AGE (at death)
5. DATE OF DEATH
6. TIME OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF NEXT OF KIN
15. SIGNATURE OF BURIAL OFFICIAL
16. SIGNATURE OF CHURCH OFFICIAL
17. SIGNATURE OF FUNERAL HOME
18. SIGNATURE OF CEMETERY
19. SIGNATURE OF CORoner
20. SIGNATURE OF JURY
21. SIGNATURE OF DISTRICT ATTORNEY
22. SIGNATURE OF PROSECUTOR
23. SIGNATURE OF DEFENSE ATTORNEY
24. SIGNATURE OF JUDGE
25. SIGNATURE OF CLERK
26. SIGNATURE OF RECORDER
27. SIGNATURE OF ARCHIVIST
28. SIGNATURE OF LIBRARIAN
29. SIGNATURE OF CURATOR
30. SIGNATURE OF ASSISTANT
31. SIGNATURE OF ATTORNEY AT LAW
32. SIGNATURE OF SHERIFF
33. SIGNATURE OF DEPUTY SHERIFF
34. SIGNATURE OF CONSTABLE
35. SIGNATURE OF JAILER
36. SIGNATURE OF WARDEN
37. SIGNATURE OF CHIEF OF POLICE
38. SIGNATURE OF DETECTIVE
39. SIGNATURE OF INSPECTOR
40. SIGNATURE OF SUPERVISOR
41. SIGNATURE OF CLERK
42. SIGNATURE OF RECORDER
43. SIGNATURE OF ARCHIVIST
44. SIGNATURE OF LIBRARIAN

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12028

CERTIFICATE OF DEATH

12017

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <u>Abingdon</u>		LENGTH OF STAY (in this place) <u>35 yrs</u>		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN <u>Abingdon</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or-Print)				4. DATE OF DEATH			
(First) <u>Viola</u>		(Middle) <u>S.</u>		(Last) <u>Norton</u>		(Month) (Day) (Year) <u>Dec. 21 19 55</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May, 20, 1896</u>		9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Servant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hollingsworth</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Harold Norton Abingdon, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443x IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Cardiovascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/18</u> , 19 <u>55</u> , to <u>12/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u> , M.D. <u>569 Revolution St. Haverde Grace, Md.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas & Son</u> , ADDRESS <u>Abingdon, Md.</u>			

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD. 1955 CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Name]
2. SEX: [Male/Female]
3. AGE: [Age]
4. DATE OF BIRTH: [Date]
5. PLACE OF BIRTH: [Place]
6. OCCUPATION: [Occupation]
7. CAUSE OF DEATH: [Cause]
8. PLACE OF DEATH: [Place]
9. TIME OF DEATH: [Time]
10. SIGNATURE OF PHYSICIAN: [Signature]
11. SIGNATURE OF REGISTRAR: [Signature]
12. DATE OF DEATH: [Date]

BUREAU V. S.

DEC 29 1955

RECEIVED

NO. 100-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12017 CERTIFICATE OF DEATH

12018

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>LECEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
24 TOWN <u>HAURE DE GRACE</u>		1 1/2 DAYS		PORT DEPOSIT		071-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>HARFORD MEMORIAL HOSP.</u>				<u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELIZABETH</u> (Middle) <u>PIERCE</u> (Last)				(Month) <u>DECEMBER</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>MARRIED</u>	<u>SEPT. 8, 1888</u>	<u>67</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own HOME</u>		<u>NEW JERSEY</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>LOTT PIERCE</u> <u>PORT DEPOSIT MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.8 IMMEDIATE CAUSE (A) <u>Peritonitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Perforated Cecum (?)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>of ovary (?)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>27</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>December 19, 1955</u> , to <u>Dec. 27, 1955</u> , that I last saw the deceased <u>alive on Dec. 27, 1955</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Breuder</u>				ADDRESS (Street, city, town, state) <u>RISENG SUN. MD.</u>			
DATE <u>Dec 29, 55</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 30, 55</u>		<u>Brookview Cem</u>		<u>RISENG SUN. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec 29, 55</u>		<u>G. L. Lewis M.D.</u>		<u>J. E. Tyson</u>		<u>RISENG SUN. MD.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12029

CERTIFICATE OF DEATH

12019

182

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Fallston</u>		LENGTH OF STAY (in this place) <u>44 1/2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Fallston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>—</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Sarah</u> (Middle) <u>Waxe</u> (Last) <u>Preston</u>				12 29 1955			
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 12, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>Clearmont Mills Md.</u>	
13. FATHER'S NAME <u>John Amblerman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs Edw. Keller 4507 B & An Rd</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				(B) <u>Chronic hypertensive cardio-vascular disease.</u>		??	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>April 4</u> , 19 <u>53</u> , to <u>Dec. 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27/55</u> , 19 <u>55</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson, M.D.</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>12-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>12-31-55</u>	NAME OF CEMETERY OR CREMATORY <u>Sanctusville</u>		LOCATION (City, town, or county) <u>Sanctusville, Harford</u>		(State) <u>Md.</u>	
24. REC'D BY REGISTRAR <u>—</u>	REGISTRAR'S SIGNATURE <u>—</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>		ADDRESS <u>—</u>			
DATE <u>1-3-56</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12018

CERTIFICATE OF DEATH

12020

Reg. Dist. No. 183

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i> <i>Maryland</i>				STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harford</i>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harford</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>213 N. Stokes</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Geese</i> <i>Richardson</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12/15/55</i> 19			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Unknown</i>	9. AGE last birthday <i>70</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Harford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Richardson</i>				14. MOTHER'S MAIDEN NAME <i>Frances Shindan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS <i>Clarence Richardson 213 Stokes Harford</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <i>Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSE(S) DUE TO <i>Vascular Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Coronary Arteriosclerosis</i>						<i>8 hrs</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/14</i> , 19 <i>55</i> , to <i>12/15</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/14</i> , 19 <i>55</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley</i> M.D.				ADDRESS (Street, city, town, state) <i>4040 Main St. Harford Md.</i>		DATE SIGNED <i>12/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/17/55</i>		NAME OF CEMETERY OR CREMATORY <i>St. James</i>		LOCATION (City, town, or county) (State) <i>Harford Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Livingston</i>		ADDRESS <i>Harford Md.</i>	
DATE <i>Dec. 16 - 1955</i>							

THIS IS THE OFFICIAL RECORD OF THE DEATH OF THE ABOVE NAMED PERSON, AS REPORTED BY THE NEAREST RELATIVE OR OTHER PERSON KNOWN TO THE DECEASED, AND AS VERIFIED BY THE OFFICIALS OF THE HEALTH DEPARTMENT. THE DEATH WAS REPORTED BY THE NEAREST RELATIVE OR OTHER PERSON KNOWN TO THE DECEASED, AND AS VERIFIED BY THE OFFICIALS OF THE HEALTH DEPARTMENT. THE DEATH WAS REPORTED BY THE NEAREST RELATIVE OR OTHER PERSON KNOWN TO THE DECEASED, AND AS VERIFIED BY THE OFFICIALS OF THE HEALTH DEPARTMENT.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1905

THE DECEASED

NAME OF DECEASED

John A. Smith
John A. Smith
John A. Smith

John A. Smith
John A. Smith
John A. Smith

John A. Smith
John A. Smith
John A. Smith

BUREAU V. S.

DEC 19 1955

RECEIVED

John A. Smith
John A. Smith
John A. Smith

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12021

12030

CERTIFICATE OF DEATH

Reg. Dist. No. 18.2

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Taylor</i>		STATE <i>Maryland</i>		COUNTY <i>Hanford</i>		STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ham Bel Air</i>		LENGTH OF STAY (In this place) <i>6 Weeks</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hamde Chase</i>		TOWN <i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Walters Nursing Home</i>				STREET ADDRESS (If rural give location) <i>823 Juniata</i>			
3. NAME OF DECEASED (Type or Print) BERNARD				4. DATE OF DEATH (Month) Dec. (Day) 28 (Year) 19 55			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>10/21/1884</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Staples Store</i>		9. AGE last birthday <i>71</i> yrs.		12. CITIZEN OF WHAT COUNTRY <i>Italy</i>	
13. FATHER'S NAME <i>Dominick Ruffini</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS <i>Mary E. Ruffini, Hamde Chase Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4437 IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 30 min.	
ANTECEDENT CAUSE(S) DUE TO (B) Chr. Hypertensive Cardio-vascular Disease						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>8</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 2, 1955 , to Dec. 28, 1955 , that I last saw the deceased alive on Dec. 26, 1955 , and that death occurred at 5:30 p.m. the causes and on the date stated above.							
SIGNATURE <i>Willard P. Hudson</i>				ADDRESS (Street, city, town, state) Forest Hill, Md.			
DATE SIGNED 12-28-55							
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>12/31/55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Air</i>		LOCATION (City, town, or county) (State) <i>Hamde Chase Md.</i>	
24. REC'D BY REGISTRAR <i>1-3-56</i>		REGISTRAR'S SIGNATURE <i>Priscilla Lowwood</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Priscilla Lowwood</i>			
DATE				ADDRESS <i>Hamde Chase Md.</i>			

JAN 5 1956

RECEIVED
JAN 5 1956

MARGIN RESERVED FOR BINDING

of information carefully. The correct
f death clearly and legibly.

12019

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.
12022-
No. 82

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>32 BELAIR</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore Avenue</u> 03X2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>7820 Aiken Avenue #14</u>			
3. NAME OF DECEASED:		4. DATE OF DEATH		5. (Month) (Day) (Year)	
(First) (Middle) (Last) (Schnorr) <u>Melvin E. SCHNOR</u>		<u>12</u> <u>9</u> <u>1955</u>			
6. SEX:	7. COLOR OR RACE:	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR	
<u>male</u>	<u>white</u>	<u>Aug. 20, 1919</u>	<u>36</u> yrs.	Months	Days
11a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Auto Salesman</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Edward Motors</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Earl Schnorr</u>		14. MOTHER'S MAIDEN NAME: <u>Ethel Fleener</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		16. SOCIAL SECURITY No.: <u>WW2 477-07-7681</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ruth N. Schnorr, 7820 Aiken Ave. #14</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>430.1</u> Immediate cause (a) <u>Coronary Sclerosis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>R. F. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-9-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rochester, Minnesota</u>	
DATE REC'D BY LOCAL REG. <u>Dec 13, 1955</u>		REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, 5305 Harford Road</u>	

15013

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

FOR THE DIRECTOR OF THE BUREAU OF THE ARMY
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12023

12031

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL WHITE HALL</u>				TOWN <u>RURAL WHITE HALL RI. X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>RUSSELL</u> (Middle) <u>CHARLES</u> (Last) <u>SEITZ</u>				(Month) <u>12-</u> (Day) <u>30</u> (Year) <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-22-1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER Co.</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES SEITZ</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ORWIG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or link.)		16. SOCIAL SECURITY NO. <u>183-18-7927</u>		17. INFORMANT & ADDRESS <u>Mrs. Ella Seitz, White Hall End</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1, 1953, to Dec. 30, 1953, that I last saw the deceased alive on Dec. 28, 1953, and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Paul D. Shaul</u> M.D.				ADDRESS (Street, city, town, state) <u>Shrewsbury Pa</u>		DATE SIGNED <u>12-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>OLD HOPEWELL</u>		LOCATION (City, town, or county) (State) <u>HOPEWELL TWP. YORK Co., Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Oshman</u>		ADDRESS <u>Stewartstown Pa</u>	
DATE <u>1-3-56</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12032

CERTIFICATE OF DEATH

12024

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>	
CITY OR TOWN <u>Burlington</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>Burlington</u>		STREET ADDRESS (if rural give location) <u>Burlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Samuel S Snowden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 11, 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Oct 15, 1869</u>	
9. AGE last birthday <u>86</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner of farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co, Md</u>		11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Fessie Snowden</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT & ADDRESS <u>Mrs. Dorothy Millington</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				5-6 yr			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>old age</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1953</u> , to <u>Dec 11, 1955</u> , that I last saw the deceased alive on <u>Dec 10, 1955</u> , and that death occurred at <u>6:47</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Audley Chullyn M.D.</u>				ADDRESS (Street, city, town, state) <u>Burlington, Md</u>			
DATE SIGNED <u>12/12/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hadams Cemetery</u>		LOCATION (City, town, or county) <u>Harford Co, Md</u>	
24. REC'D BY REGISTRAR <u>Dec 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Cornelia W. Kirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Burlington, Md</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12033
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12025
Reg. Dist. 180
No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Edgewood		LENGTH OF STAY (in this place) 14 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) Edgewood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) Marvin (Middle) M. (Last) Stokley				4. DATE OF DEATH (Month) (Day) (Year) December 10 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 8-5-77	9. AGE last birthday: 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Mechanic		10b. KIND OF BUSINESS OR INDUSTRY: Automobile		11. BIRTHPLACE (State or foreign country): North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME: Charles L. Stokley				14. MOTHER'S MAIDEN NAME: Susan C. Brothers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of Spanish American)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Wash., Marion A. Stokley, 4803-7th St., N.E., D.C.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Carcinoma tongue with metastasis DUE TO to lungs Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic C⁴ Disease							
19a. DATE OF OPERATION: April 1, 1955		19b. MAJOR FINDING OF OPERATION: carcinoma tongue Radon implanted					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Derald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/2/11/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Dec. 14, 1955		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Fairfax, Va.	
DATE REC'D BY LOCAL REG. Dec 14, 1955		REGISTRAR'S SIGNATURE Norma E. Moore		24. FUNERAL DIRECTOR ADDRESS W.W. Chambers, Riverdale, Maryland.			

BUREAU V. S.

DEC 19 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

12034 **CERTIFICATE OF DEATH**Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>X</u> TOWN <u>Aberdeen</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stephenay Road</u> <u>Aberdeen, Md</u>				STREET ADDRESS (If rural give location) <u>RD #1, Stephenay Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>POLLY</u>		(Middle) <u>ANNE</u>		(Last) <u>SWICK</u>		(Month) (Day) (Year) <u>Dec 31 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 25, 1955</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>6</u>	Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Robert Swick</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Jean Rowser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Richard R Swick</u> <u>Stephenay Road, Aberdeen, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4342</u> <u>Cardiac dilatation</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary edema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8:40</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DCA 8:40 AM</u> , to <u>Dec 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>55</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Ardis Caputo</u> ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. US Army Hospital Aberdeen Pr Gr, Md 2 Jan 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bennshoff Cemetary</u>		LOCATION (City, town, or county) (State) <u>Johnstown, Pa</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 3-1956</u>		REGISTRAR'S SIGNATURE <u>Nellie G Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Yarning. Aberdeen Md.</u>		ADDRESS	

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Source: U.S. Census Bureau, *Marriage, Divorce, Remarriage in the 1990s*, Washington, D.C., 1995.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12027

12035 CERTIFICATE OF DEATH

Reg. Dist. No. 181

Trans 84: File 6191-1/6/56 L

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Harford</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		TOWN <i>Harford</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Box #93 Rural #1</i>				STREET ADDRESS (If rural give location) <i>Box #93 Rural #1</i>			
3. NAME OF DECEASED (Type or Print) <i>Andrew E. Thomas</i>				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>12</i> (Year) <i>1955</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov 17th 1877</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self emp. farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-32-8978</i>		17. INFORMANT & ADDRESS <i>Herman H. Thomas Harford #1</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Arterio Sclerosis Under Venous</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Arterio</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Cerebral Aneurysm</i>							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>Dec 11, 1955</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 11, 1955</i> , to <i>Dec 12, 1955</i> , that I last saw the deceased alive on <i>Dec 11, 1955</i> , and that death occurred at <i>9:00</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Perry</i> M.D.				ADDRESS (Street, city, town, state) <i>Harford #1</i>		DATE SIGNED <i>12/12/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/15/55</i>		NAME OF CEMETERY OR CREMATORY <i>Angle Hill Cemetery</i>		LOCATION (City, town, or county) (State) <i>Harford, Md.</i>	
24. REC'D BY REGISTRAR <i>Dec 13-55</i>		REGISTRAR'S SIGNATURE <i>Willie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barry</i>		ADDRESS <i>Harford, Md.</i>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12036

CERTIFICATE OF DEATH

Reg. Dist. No. 182

12028

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Bel Air Rural</i>				TOWN <i>Bel Air Rural</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Walters Nursing Home</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Oscar M. Thompson</i>				<i>December 9 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Nov 18, 1870</i>	9. AGE last birthday <i>85</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beloved Grandfather</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Operator</i>		11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>W. M. H. Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Anna E. Huff</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT & ADDRESS <i>Roy G. Gault</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>						<i>2 days</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<i>Arteriosclerosis</i>		<i>?</i>	
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/7</i> , 19 <i>55</i> , to <i>12/9</i> , 19 <i>55</i> ; that I last saw the deceased alive on <i>12/7</i> , 19 <i>55</i> , and that death occurred at <i>6A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Gerald E. Palmer</i> M.D.				ADDRESS (Street, city, town, state) <i>Bel Air Md.</i>		DATE SIGNED <i>12/9/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec 12, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Broad Creek Cn</i>		LOCATION (City, town, or county) (State) <i>Harford Co Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Corneilia W. Kirk</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. B. Bailey</i>		ADDRESS <i>Washington Md.</i>	
DATE <i>Dec. 15, 1955</i>							

CERTIFICATE OF DEATH

2025-001-1000

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BUREAU V. S.

DEC 21 1955

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IN215KCL1012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12037

CERTIFICATE OF DEATH

Reg. Dist. No. 12020

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY HARFORD	MARYLAND	STATE PA.	COUNTY YORK
CITY (If outside corporate limits, write RURAL and give nearest town) CARRIFF	LENGTH OF STAY (in this place) 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - DELTA 75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) R.D. #2	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) WILLIAM	(Middle) JAMES	(Last) UREY	
5. SEX: M		6. COLOR OR RACE: W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED		8. DATE OF BIRTH: MAR. 25, 1883	
9. AGE last birthday: 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): CHESTER, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: GEORGE UREY		14. MOTHER'S MAIDEN NAME: MARGARET BLACKBURN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: CURTIS UREY, DALLASTOWN, PA.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1		6 1/8 hours	
ANTECEDENT CAUSE (S) Coronary atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Coronary sclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/10 , 19 55 , to 12/12 , 19 55 , that I last saw the deceased alive on 12/10 , 19 55 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
SIGNATURE Benj. J. J. J.		DATE SIGNED 12/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-15-55	
NAME OF CEMETERY OR CREMATORY AIRVILLE		LOCATION (City, town, or county) (State) AIRVILLE, PA.	
DATE REC'D BY LOCAL REGISTRAR 12.14.55		REGISTRAR'S SIGNATURE Prudence Lowrod	
24. FUNERAL DIRECTOR		ADDRESS JOHN H. HARKINS, DELTA, PA.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

DEC 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12038 CERTIFICATE OF DEATH

12031

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL WHITE HALL</u>				TOWN <u>RURAL WHITE HALL</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>J.</u> (Middle) <u>NELSON</u> (Last) <u>WILEY</u>				(Month) <u>12</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7-4-1860</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID WILEY</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN WILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Samson Wile, Whitehall Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic myocarditis.</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General infarction fold age.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 15, 1955</u> , to <u>Dec 30, 1955</u> , that I last saw the deceased alive on <u>Dec. 29, 1955</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samson H. Gemmill</u>				ADDRESS (Street, city, town, state) <u>Stewartstown Pa.</u>		DATE SIGNED <u>Dec. 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>NORRISVILLE</u>		LOCATION (City, town, or county) (State) <u>NORRISVILLE, HARFORD CO., MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Barilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Chubb</u> ADDRESS <u>Stewartstown Pa.</u>			
DATE <u>1-3-56</u>							

1963

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1963 CERTIFICATE OF DEATH

State of Maryland

LOCAL HEALTH DEPARTMENT OF BALTIMORE

RECEIVED
JAN 5 1966
BUREAU V. E.

THIS CERTIFICATE OF DEATH IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE LOCAL HEALTH DEPARTMENT OF THE CITY OR COUNTY IN WHICH THE DEATH OCCURRED. IT IS TO BE RETURNED TO THE BUREAU OF VITAL STATISTICS OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, WITHIN 10 DAYS OF THE DATE OF DEATH.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12039 CERTIFICATE OF DEATH

12030

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i> <i>Maryland</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL OR one give nearest town) <i>Frost Green</i>				CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frost Green</i>			
TOWN <i>6 yrs.</i>				TOWN <i>6 yrs.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Noah</i> (Middle) <i>Isaac</i> (Last) <i>Wimmer</i>				(Month) <i>12/12/55</i> (Day) <i>19</i> (Year)			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Dec. 17/1878</i>	
9. AGE last birthday <i>76</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Capitol Hill, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>				10b. BIRTHPLACE (State or foreign country) <i>Capitol Hill, Va.</i>			
13. FATHER'S NAME <i>Harvey Wimmer</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Wilson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If Yes, give war or dates of service) <i>Unknown</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>			
17. INFORMANT & ADDRESS <i>Mr. Rodney King, Frost Green, Md.</i>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
1 IMMEDIATE CAUSE (A) <i>420.0</i>				<i>Pulmonary Edema</i>			
2 ANTECEDENT CAUSE(S) DUE TO				<i>Heart Failure</i>			
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>Arteriosclerotic Heart Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			
21e. INJURY OCCURRED White at work Not white at work				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-12-1955, to 12-13-1955, that I last saw the deceased alive on 12-12-1955, and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>W. Rodney King</i>				DATE SIGNED <i>12-14-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				24. REC'D BY REGISTRAR			
DATE THEREOF <i>12/15/55</i>				NAME OF CEMETERY OR CREMATORY <i>Spisutia</i>			
LOCATION (City, town, or county) (State) <i>Perryman Md.</i>				25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Rodney King</i>			
26. ADDRESS <i>12-15-55</i>				27. ADDRESS <i>W. Rodney King</i>			

1908 CERTIFICATE OF DEATH

WEST COAST, MD.

TO BE FILLED BY THE REGISTRAR OF DEATHS

NAME OF DECEASED

AGE AT DEATH
SEX
RACE
BIRTH DATE
BIRTH PLACE

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

DATE OF BURIAL
PLACE OF BURIAL

NAME OF PHYSICIAN
NAME OF MINISTER OF THE GOSPEL

NAME OF WITNESS
NAME OF WITNESS

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BUREAU V. S.

DEC 19 1955

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TO BE KEPT IN THE
OFFICE OF THE
REGISTERAR OF DEATHS
BALTIMORE, MD.